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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 06/26/2012 TNPL537157 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 303 SOUTH ROYAL OAKS BLVD **BELVEDERE COMMONS OF FRANKLIN** FRANKLIN, TN 37064 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 624 1200-08-25-.06 (5)(b)1. Administration D 624 (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility: This Rule is not met as evidenced by: Based on personnel file review and interview, it was determined the facility failed to have documentation of the offer of influenza vaccination for 4 (Employee #1, #2, #4, #5) of 5 sampled personnel files. The findings included:

D 625

Personnel file review for Employee # 1, #2, #4 and #5 revealed there was no documentation of the offer of influenza vaccine for any of the 4 employees.

During an interview at the time of the finding, the Wellness Director verified this finding.

D 625 1200-08-25-.06 (5)(b)2. Administration

(5) Infection Control

Division of Health Care Facilities

(b) An ACLF shall have an annual influenza vaccination program which shall include at least:

A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications:

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLE	TED	
		TNPL537157		B. WING		06/2	6/2012
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
BELVEDI	ERE COMMONS OF F	RANKLIN		H ROYAL OA I, TN 37064	AKS BLVD		
(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 625	was determined the documentation of a influenza vaccinatio #5) of 5 sampled properties. The findings include Personnel file revies and #5 revealed the signed declination any of the 4 employers.	et as evidenced by: el file review and inte e facility failed to have a signed declination of on for 4 (Employee # ersonnel files. ed: ew for Employee #1, a ere was no document of the influenza vaccuses.	e of the 1, #2, #4, #2, #4, Itation of a ination for	D 625			
D 627	During an interview at the time of the finding, the Wellness Director verified this finding. 1200-08-2506 (5)(b)4. Administration (5) Infection Control (b) An ACLF shall have an annual influenza vaccination program which shall include at least: 4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to perform an annual evaluation of the		D 627				
,		on program and reas		1			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	FATE, ZIP CODE		
BELVEDI	ERE COMMONS OF I	FRANKLIN		H ROYAL OA I, TN 37064	AKS BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 627	Assisted Living We facility had not perf	age 2 on 6/26/12 at 3:00 Fellness Director stated formed an annual evalum and reasons for	the	D 627	·		
D 629	utilize standard pre guidelines establis Control and Preve transmission of inf communicable disc a hand hygiene pre 1. Use of alcohol non-antimicrobial of	its employees shall a ecautions in accordar hed by the Centers fo ntion (CDC) for preve ections, HIV, and eases, including adhe ogram which shall inco- based hand rubs or or antimicrobial soap ach resident contact i	nce with or Disease enting erence to clude: use of and water	D 629			
	Based on docume determined the factorisease Control at for cleaning glucon. The findings include Review of Infection Glucose Monitoring published by the Confollowing"An under the following"An under the following"		enters for guidelines Blood stration f blood				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLI	
NAME OF D	ROVIDER OR SUPPLIER	1111 2007 107	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
	ERE COMMONS OF F	FRANKLIN		H ROYAL O	AKS BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
	HIV) through conta supplies if devices administration (e.g. fingerstick devices, Unsafe practices blood glucose and have contributed to put persons at risk blood glucose metewithout cleaning arruses." During an interview Licensed Practical was 1 glucometer is stated currently the their glucose check morning. When as the glucometer is of time a day, after the check all 3 residen 1200-08-2507 (6) (6) An ACLF shall follows: (a) Upon dischargunused medication resident, family meunless specifically	s (HBV, hepatitis C viminated equipment a used for testing and/, blood glucose meter insulin pens) are shouring assisted moninsulin administration transmission of HBV for infection include: ar for more than one and disinfecting it in between the Memory Care I were are 3 residents the sed with the glucome ked by the surveyor I cleaned, LPN #1 state e glucometer had be	and or insulin ers, ared. itoring of that / or have Using a person etween AM, ed there Jnit. She at get ter each now often ed one en used to d ons as ent, o the sentative ending	D 629			
		et as evidenced by: tion, and interview, it	was				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER TNPL537157			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2012	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
BELVEDE	RE COMMONS OF I	FRANKLIN		H ROYAL O. I, TN 37064			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	discontinued medic Community) of 3 m Memory Care Unit The findings includ 1. Observation on 6 Community, reveal was 1 Glucagon Ki 2/21/12. During an interview (LPN) #1, present in the Pink Community and the facility aboverified the medical of after the resident 2. Observation on 6 Community, reveal refrigerator there w 75/25 and 1 injection of the findings in the resident who had resided at the facility discontinued about	ility failed to dispose cations in 2 (Pink and dedication storage are (MCU). led: 6/26/12 at 8:30 AM in led in the medication it with an expiration do an expiration do an expiration do an expiration do an expiration was not properly at was discharged. 6/26/12 at 8:40 AM in led in the medication was 1 bottle Humulog	I Blue eas in the Pink cart there late of Nurse eve finding eagon Kit ischarged eas in the eas in the Blue eas in the Blue Insulin the time estated the grinsulin eated the tions still dright been #1	D 710			
D 712	disposed of by the		, ,	D 712			
,	(6) An ACLF shall follows:	I dispose of medication	ons as				1

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Division of Health Care Facilities

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 06/26/2012 TNPL537157 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 303 SOUTH ROYAL OAKS BLVD BELVEDERE COMMONS OF FRANKLIN FRANKLIN, TN 37064 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 712 D 712 Continued From page 5 (c) Any non-scheduled drug or device that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be properly disposed of at the ACLF in the presence of another licensed or certified professional. This Rule is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to dispose of expired medications. The findings included: 1. Review of the facility medication policy for expired medications revealed Humulin, Novolin, Lantus and Novolog insulins should be discarded 28 days from the time they are opened. The policy documented Tubersol must be discarded 30 days after it had been opened. 2. Observation on 6/26/11 at 8:45 AM, revealed in the medication refrigerator in the MCU there were 2 opened containers of Tubersol. Neither contained documentation of the date they had been opened. Also in the refrigerator was 1 vial Novolog insulin with an expiration date of 3/12/12 and 1 opened vial Humulin R insulin with documentation it had been opened 6/14/11. During an interview, LPN #1 and the Wellness Director for the MCU, both present at the time of the finding verified the above findings. Both confirmed it could not be determined when the 30 days on the Tubersol would be since the bottles had not been dated when opened.

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL537157		A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2012	
POVIDER OR SUPPLIER	TRF 237 137	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
	FRANKLIN	303 SOUT	H ROYAL O		
(EACH DEFICIENC)	MUST BE PRECEDED BY	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE COMPLETE
3. Observation on 6 the Assisted Living Novolog insulin dat 5/15/12, 1 bottle Hibeen opened 5/19/dated it had been ovial Tubersol that dibeen opened. During an interview Wellness Director of the above finding to timely discard of confirmed it could it days on the Tubers dated when opened.	6/26/12 at 9:30 AM, r Unit (AL) there was ed it had been open- umulog insulin dated 12, 1 bottle Novolog opened 5/13/12 and r id not document who of the AL, present at gs verified the facility the expired insulins not be determined who sol would be since it id.	1 bottle ed it had insulin 1 opened en it had AM, the the time had failed She nen the 30 was not	D 712		
(7) An ACLF shall follows: (c) Dietary services 5. An ACLF shall kitchen. This Rule is not m Based on observate determined the fact and sanitary kitcher (MCU) and the Assertations.	provide personal sees. maintain a clean and the second interview, it will be second in the Memory Casistant Living (AL) un	rvices as d sanitary was n a clean re Unit			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L.) Continued From pa 3. Observation on 6 the Assisted Living Novolog insulin dat 5/15/12, 1 bottle Hubeen opened 5/19/dated it had been ovial Tubersol that dibeen opened. During an interview Wellness Director of the above finding to timely discard of confirmed it could r days on the Tubers dated when opened 1200-08-2507 (7) (7) An ACLF shall follows: (c) Dietary service 5. An ACLF shall kitchen. This Rule is not m Based on observation determined the fact and sanitary kitches (MCU) and the Assistance is summer to the property of the pr	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM. Continued From page 6 3. Observation on 6/26/12 at 9:30 AM, represented the Assisted Living Unit (AL) there was Novolog insulin dated it had been opened 5/15/12, 1 bottle Humulog insulin dated been opened 5/19/12, 1 bottle Novolog dated it had been opened 5/13/12 and vial Tubersol that did not document whe been opened. During an interview on 6/26/12 at 9:30 / Wellness Director of the AL, present at of the above findings verified the facility to timely discard of the expired insulins. confirmed it could not be determined wild days on the Tubersol would be since it dated when opened. 1200-08-2507 (7)(c)5. Services Provided the facility for the ACLF shall provide personal services. 5. An ACLF shall maintain a clean and kitchen. This Rule is not met as evidenced by: Based on observation and interview, it determined the facility failed to maintain and sanitary kitchen in the Memory Carlot.	STREET ADD 303 SOUT FRANKLIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 3. Observation on 6/26/12 at 9:30 AM, revealed in the Assisted Living Unit (AL) there was 1 bottle Novolog insulin dated it had been opened 5/15/12, 1 bottle Humulog insulin dated it had been opened 5/19/12, 1 bottle Novolog insulin dated it had been opened 5/13/12 and 1 opened vial Tubersol that did not document when it had been opened. During an interview on 6/26/12 at 9:30 AM, the Wellness Director of the AL, present at the time of the above findings verified the facility had failed to timely discard of the expired insulins. She confirmed it could not be determined when the 30 days on the Tubersol would be since it was not dated when opened. 1200-08-2507 (7)(c)5. Services Provided (7) An ACLF shall provide personal services as follows: (c) Dietary services. 5. An ACLF shall maintain a clean and sanitary kitchen. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a clean and sanitary kitchen in the Memory Care Unit (MCU) and the Assistant Living (AL) unit,	STREET ADDRESS, CITY, S 303 SOUTH ROYAL OF FRANKLIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 6 3. Observation on 6/26/12 at 9:30 AM, revealed in the Assisted Living Unit (AL) there was 1 bottle Novolog insulin dated it had been opened 5/15/12, 1 bottle Humulog insulin dated it had been opened 5/15/12, 1 bottle Humulog insulin dated it had been opened vial Tubersol that did not document when it had been opened. During an interview on 6/26/12 at 9:30 AM, the Wellness Director of the AL, present at the time of the above findings verified the facility had failed to timely discard of the expired insulins. She confirmed it could not be determined when the 30 days on the Tubersol would be since it was not dated when opened. 1200-08-2507 (7)(c)5. Services Provided (7) An ACLF shall provide personal services as follows: (c) Dietary services. 5. An ACLF shall maintain a clean and sanitary kitchen. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a clean and sanitary kitchen in the Memory Care Unit (MCU) and the Assistant Living (AL) unit,	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 3. Observation on 6/26/12 at 9:30 AM, revealed in the Assisted Living Unit (AL) there was 1 bottle Novolog insulin dated it had been opened 5/13/12, 1 bottle Novolog insulin dated it had been opened 5/13/12, 1 bottle Novolog insulin dated it had been opened 5/13/12 and 1 opened vial Tubersol that did not document when it had been opened. During an interview on 6/26/12 at 9:30 AM, the Wellness Director of the AL, present at the time of the above findings verified the facility had failed to timely discard of the expired insulins. She confirmed it could not be determined when the 30 days on the Tubersol would be since it was not dated when opened. 1200-08-2507 (7)(c)5. Services Provided (7) An ACLF shall provide personal services as follows: (c) Dietary services. 5. An ACLF shall maintain a clean and sanitary kitchen. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a clean and sanitary kitchen in the Memory Care Unit (MCU) and the Assistant Living (AL) unit,

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Division	of Health Care Faci	lities					
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER TO THE STATE OF			(X2) MULTIP A. BUILDING B. WING		(X3) DATE S COMPLI	
NAME OF D	DOVIDED OF SUPPLIES	1141 2337107	STREET ADD	DRESS CITY, S	TATE, ZIP CODE		
	ROVIDER OR SUPPLIER ERE COMMONS OF F	FRANKLIN	303 SOUT	H ROYAL O			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 732	6/26/12 at 8:30 AM communities. Each area that contained stove/microwave, at a. Observation of the Community on 6/26 following: In the refulastic bag grated of when it had been or refrigerator, 1 open documentation of a been placed in the molded sweet potano documentation it had been placed inside of the refrigerany liquid and for The kitchen counter of cookies. In the repartially eaten waff lower kitchen cabir undated bags of potant potan	ring a tour of the MCU revealed it was divided community had a kit a refrigerator, sink, and cabinets. The kitchen in the Pink B/12 at 8:40 AM, revealed and placed in a can Ensure with no a resident name or where the refrigerator, 1/2 uncounted to 1 large container of what it was opened in the refrigerator. Begrator and freezer container and freezer and freezer container and freezer container and freezer container	ded into 3 tchen called the large mentation the hen it had vered liquid with dor when both the ntained red bowl was a age. In the en, es. elealed in iner ranch cheese, ated when of the	D 732	DEFICIENCY		
5 To	revealed the lower dried food spills. In	cabinets in the kitch cabinet doors containside the cabinets, the to chips and cookies	ined many ere were 5				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SI COMPLE	ETED	
	TNPL537157	OTDEET ADD	DESC OITY S	TATE ZID CODE	06/2	6/2012	
NAME OF PROVIDER OR SUPPLIER BELVEDERE COMMONS OF	FRANKLIN	303 SOUT	DDRESS, CITY, STATE, ZIP CODE TH ROYAL OAKS BLVD IN, TN 37064				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
the cabinet doors h	age 8 by had been opened. by had missing knobs to be did not have a do	open the	D 732			· · · · · · · · · · · · · · · · · · ·	
6/26/12 at 9:15 AM container cottage of pimento cheese will either had been operefrigerator and free and food spills. Observation in the revealed there were	he Yellow Community I, revealed there was cheese and 1 large of the no documentation bened. Both the inside ezer contained many lower kitchen cabine as a large bags of potented when they had better the same of the same o	ontainer when e of the r liquid ets ato chips					
2. Observation of t 6/26/12 at 9:40 AN refrigerator there v cheese dressing a	the kitchen in AL Unit I revealed in the walk vas 1 gallon containe nd 1 gallon container of dated when they ha	k-in r blue r cocktail					
MCU, present duri the above findings Director for the AL employee refrigera The Dietary Mana the AL kitchen, ve	vs, the Wellness Directing the tour of the MCU. The Well, present during the teator verified the above ger, present during the rified the above finding the liquids should be labored.	CU, verified beliness cour of the findings. he tour of ings. She					
D 832 1200-08-2508 (9 and Transfers	,		D 832	· ·			
survey staff with to	ting secured units sha welve (12) months of ance information spec	the					

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPL	
NAME OF P	ROVIDER OR SUPPLIER	1111 2007 107	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		***
	ERE COMMONS OF	FRANKLIN		H ROYAL OA I, TN 37064	AKS BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 832	(b) Ongoing and useach resident's in performed a quarter appropriateness of this Rule is not medical was determined the documentation of eteam quarterly revisappropriateness in (Resident #4, #5) of (MCU) residents. The findings included the was admitted to Diagnoses included documentation that interdisciplinary team the was admitted to diagnoses included was documentation that interdisciplinary team the was admitted to diagnoses included was documentation that interdisciplinary team the was admitted to diagnoses included was documentation that interdisciplinary team the was admitted the was ad	s residents at its ann ap-to-date documental terdisciplinary team berly review as to the fiplacement in the secret as evidenced by: record review and interesident's interesident's interesident's interesident's interesident to show the resident for 2 sampled Memory of 2 sampled Memory of 2 sampled Memory of 2 sampled Memory of 3 decimental. There we am had been complesive for Resident #5 reto the MCU on 3/17/10 decimental for a quarterly review and a quarterly review of the fire of the	ation that has cured unit; terview, it re lisciplinary lent's 2 y Care Unit revealed vas no ws by the ted. revealed 11. Her e. There w on	D 832			
D1036	1200-08-2510 (8)(b) Life Safety		D1036			
	(8) An ACLF shall	ensure that:					

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Division	of Health Care Faci	lities					
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE	***	
	ERE COMMONS OF F	FRANKLIN		H ROYAL O			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D1036	from the kitchen, for or other resident action or other resident action of the Based on observat determined the faci supplies away from in 3 (Kitchens in Pin Memory Care) of 4 Observation of the Unit (MCU) revealed cleaning supplies a stored in the lower Pink, Blue and Yell During an interview	es janitorial supplies ood storage area, din ccessible areas; et as evidenced by: ion and interview, it villity failed to store jand the kitchen/ food stonk, Blue, Yellow Unit kitchen areas toured 3 kitchens in the Med multiple containers and aerosol disinfecta cabinets in the kitches	vas itorial orage area s in l. mory Care s of ants were ens of the	D1036			
D1038	frequently as need lint, soil and dirt. This Rule is not m Based on observat determined the face	ensure that: ans floor and dryer vered to prevent accum et as evidenced by: tion and interview, it vereiting failed to ensure to define the community) of the clean.	ulation of was he dryer	D1038			
		26/12 at 10:00 A M , re	evealed the				

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Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 06/26/2012 TNPL537157 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 303 SOUTH ROYAL OAKS BLVD BELVEDERE COMMONS OF FRANKLIN FRANKLIN, TN 37064 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D1038 D1038 Continued From page 11 dryer vents in the laundry rooms in the Pink and Blue Community of the Memory Care Unit (MCU) revealed the vents had a heavy build up of lint. During an interview, at the time of the findings, the MCU Wellness Director verified the heavy lint build up in the dryer vents. D1040 D1040: 1200-08-25-.10 (10)(a) Life Safety (10)An ACLF shall maintain its physical environment in a safe, clean and sanitary manner by doing at least the following: (a) Prohibit any condition on the ACLF site conducive to the harboring or breeding of insects, rodents or other vermin: This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the physical environment in a clean and sanitary manner in the Memory Care Unit (MCU). The findings included: 1. Observation in the Pink Community on 6/26/12, revealed in the resident bathrooms in rooms 101,108 and 112 there was mold in the resident's shower. The commode in each above room had a black and red ring at the top of the water line, and the commode was very dirty around the inside top of the commode. 2. Observation in the Blue Community on 6/26/12 revealed in the resident bathrooms in rooms 208 and 209 there was mold in the showers. Each commode had a black and red ring at the top of the commode water line and,

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Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED		
		TNPL537157		B. WING		06/2	26/2012
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
BELVED	ERE COMMONS OF F	FRANKLIN		H ROYAL O	AKS BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D1040	Continued From pa	age 12	Command Of the	D1040			
	both commodes were very dirty around the inside top of the commodes.						
	3. Observation in the Yellow Community on 6/26/12 revealed room 305 and 308 had mold in the showers. Each commode had a black and red ring at the top of the water line and. Both commodes were very dirty around the inside top of the commodes. During an interview at the time of the findings, the MCU Wellness verified the facility had failed to maintain a clean and sanitary environment.						
			ailed to				
D1202	1200-08-2512 (2)	(a) Resident Record	s	D1202			
		rd. An ACLF shall en sonal record includes ving:					
	status and number health insurance p	Security Number, vet r, marital status, age, rovider and number, ledicaid number, and resident;	sex, any including				
	Based on medical was determined the medical record incommer and maritation #3, #4 #5) of 5 sand The findings included Medical record reviews	·	sure the and ent # 2, #3, #4 and		·		

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL537157			(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED - 06/26/2012		
NAME OF P	ROVIDER OR SUPPLIER	1141 2007 107	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE			
	ERE COMMONS OF F	FRANKLIN		TH ROYAL OAKS BLVD N, TN 37064				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
D1202	Continued From pa	ge 13	- Comment	D1202				
	veteran status or m	arital status.					(C-	
	Assisted Living (AL	at the time of the fin) Wellness Director s n obtaining this requi	stated the					
D1204	1200-08-2512 (2)	(c) Resident Records	5	D1204				
		d. An ACLF shall en sonal record includes ring:						
	preferred physician nursing home, and	ress of the resident '	st and is from the					
	Based on medical was determined the medical record incl	et as evidenced by: record review and inteleted to enstuded the resident's paint home for 5 (Restampled residents.	ure the preferred					
	The findings includ	ed:						
	and #5 revealed th	iew for Resident #1, ere was no documer 's preferred pharmac	ntation of					
		v at the time of the fir stated the facility had ired information.						
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NAME OF 51	30,4050 00 011001150	TNPL537157	STREET ADD	DDRESS, CITY, STATE, ZIP CODE					
	ROVIDER OR SUPPLIER ERE COMMONS OF I	FRANKLIN	303 SOUT	H ROYAL O	AKS BLVD				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
D1223	Continued From pa	ige 14		D1223					
D1223	1200-08-2512 (5)	(a) Resident Records	}	D1223			:		
	(5) Plan of care.								
	each resident admi and participation fro 's legal representa other licensed heal delivering patient s admission. The pla and/or revised as of	develop a plan of car itted to the ACLF with om the resident or the tive, treating physicial th care professionals ervices within five (5) n of care shall be revelanges in resident no than semi-annually be individuals.	n input e resident in, or or entity days of riewed eeds			,			
	Based on medical was determined the plan of care (POC)	et as evidenced by: record review and int e facility failed to devi within 5 days of adm I #5) of 5 sampled res	elop a nission for						
	The findings includ	ed:							
		eview for Resident # mission date of 1/6/1 ted 2/10/12.							
	documented an ad	eview for Resident #9 mission date of 3/17/ record for the surve	11. There						
	Wellness Director #4 had not been do	v at the time of the fir verified the POC for I one within 5 days of a ctor stated she was u tesident #5.	Resident admission.						
							, Lippe		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL537157		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2012
NAME OF D	ROVIDER OR SUPPLIER	INFE537157	STREET ADD	RESS CITY S	TATE, ZIP CODE	00/20/2012
	ERE COMMONS OF I	RANKLIN	303 SOUT	H ROYAL O	AKS BLVD	
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D1608	Continued From pa	ige 15		D1608		
D1608	1200-08-2516 (3)	Disaster Preparedne	ess	D1608		
	(3) An ACLF shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes:					
*	form to be provided	submitting a question of by the Tennessee dement Agency; and	naire on a			
		cumentation of partic available to survey s on.				
	This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to participate in the Tennessee Emergency Management Agency (TEMA) emergency plan on an annual basis. The findings included:					
	During an interview on 6/26/12 at 1:45 PM, the Administrator stated the facility did not participate in the TEMA emergency plan.					

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	<u> </u>	TNPL537157				02/2	1/2012
NAME OF P	ROVIDER OR SUPPLIER		!		STATE, ZIP CODE		
BELVED	ERE COMMONS OF I	FRANKLIN		TH ROYAL C N, TN 37064			
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D 002				D 002			
Division of H	ealth Care Facilities				TITLE		(X6) DATE
אוט ווטופועיכ חו	caiui Care Facillues				11120		. ,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
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If continuation sheet 1 of 1

STATEMEI NO PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM TNPL537157	MBER: A.	2) MULTIPLE CONSTRUCTION BUILDING WING	-	SURVEY LETED
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS	S, CITY, STATE, ZIP CODE		
BELVEC	DERE COMMONS OF F	RANKLIN	303 SOUTH ROFRANKLIN, TN	DYAL OAKS BLVD 37064		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL PR	PROVIDER'S PLAN OF C EFIX (EACH CORRECTIVE ACTIVE AG CROSS-REFERENCED TO TA DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 624	1200-08-2506 (5)(b)1. Administration	D 6	24/1		
	(5) Infection Contro	ı		4.0		
		nave an annual influe n which shall include a		7.4%		
	The offer of influ- and independent pra- documented evidence another vaccine sou	penza vaccination to a actitioners or accept ce of vaccination from tree or facility.				
	This Rule is not met Based on personnel was determined the documentation of the vaccination for 4 (Em sampled personnel fi	file review and Intervi facility failed to have e offer of influenza aployee #1, #2, #4, #5				
	The findings included	1:	0			
	Personnel file review and #5 revealed then the offer of influenza employees.	e was no documental	tion of	Facility will documen on all employees' status vaccination offers and by employee kept in the file. This will be done a	of influenza signed copy oir respective	08/08/12
,	During an interview a Wellness Director ver	t the time of the findir rified this finding.	ng, the	year. This will be monitored by Assistant Director a Director. New and set	ored annually nd Wellness	
D 625	1200-08-2506 (5)(b)	2. Administration	D 625	signed by employee at	nd placed in	
((5) Infection Control			employee file. This will all employees. Reason	will be stated	
	(b) An ACLF shall ha vaccination program v			in file each year why vac declined. RECEIVED	cination was	
fi	 A signed declination all who refuse the other than medical collins. 	e influenza vaccinatio		JUL 1 1 2012		
	Ith Care Facilities MRECTOR'S OR PROVIDER	m William	(Rul) &	ullum TITLE EXECUT		(XB) DATE 7-9-1

PAGE 18/30 * RCVD AT 8/30/2012 6:33:38 PM [Central Daylight Time] * SVR:NAS-LCLFAX2/3 * DNIS:8093 * CSID:96158715728 * DURATION (mm-ss):05-57

_ Division	of Health Care Faci	litles					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU TNPL537157	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2012	
		INFL03/10/		20500 0774	STATE, ZIP CODE	0012	012012
1	303 SOL		303 SOUT	JTH ROYAL OAKS BLVD LIN, TN 37064			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROVIDER OF THE APPROPRIES OF THE APPROVIDER OF THE	JLD BE	(X5) COMPLETE DATE
D 627		et as evidenced by: I file review and inter facility failed to have signed declination or in for 4 (Employee #1 resonnel files. Id: If the imployee #1, # re was no document if the influenza vaccio est. In the time of the find erified this finding. In the imployee #1 In the im	the the 2 2, #4, ation of a nation for the ding, the	D 625	2. Facility will document indivon all employees' status of infvaccination offers and signed by employee kept in their respille. This will be done annually year. This will be monitored at by Assistant Director and W. Director. New and separate mentation will be done annua signed by employee and pla employee file. This will be do all employees. Reason will be in file each year why vaccination declined.	luenza I copy bective y each nually eliness docu- lly and ced in one on stated	08/08/12
	Based on Interview, I failed to perform an a influenza vaccination non-participation.	t was determined the annual evaluation of program and reason	the				

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TATEMEN	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
IND PLAN	OF CORRECTION	IDENTIFICATION NU	IWREK:	A. BUILDIN	IG	1		
		TNPL537167		B. WING		06/2	6/2012	
NAME OF P					STATE, ZIP CODE			
BELVED	ERE COMMONS OF I	FRANKLIN	303 SOUT	ITH ROYAL OAKS BLVD IN, TN 37084				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETE DATE	
D 627	During an interview Assisted Living We facility had not perf	Intinued From page 2 Ing an interview on 6/26/12 at 3:00 PM, the sisted Living Wellness Director stated the littly had not performed an annual evaluation of influenza program and reasons for a-participation.			3. Facility will document on all employees' status of vaccination offers and si by employee kept in their file. This will be done and year. This will be monitor	of influenza igned copy respective nually each ed annually	08/08/12	
D 629	non-participation. 1200-08-2506 (5)(c)1. Administration (5) Infection Control (c) An ACLF and its employees shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include: 1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each resident contact if hands are not visibly soiled;			D 629	by Assistant Director an Director. New and sepa mentation will be done a signed by employee and employee file. This will tall employees. Reason win file each year why vaccideclined.	d Wellness arate docu- nnually and d placed in be done on ill be stated		
	This Rule is not met as evidenced by: Based on document review and interview, it was determined the facility failed to follow Centers for Disease Control and Prevention (CDC) guidelines for cleaning glucometers. The findings included: Review of infection Prevention during Blood Glucose Monitoring and Insulin Administration published by the CDC documented the following"An underappreciated risk of blood						7777	

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TATALEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (A) PROVIDER OR SUPPLIER BELVEDERE COMMONS OF FRANKLIN (A) SUMMAY STATEMENT OF DEFICIENCIES (B) SUMMAY STATEMENT OF DEFICIENCIES (B) SUMMAY STATEMENT OF DEFICIENCIES (B) CATHERY WAS THE PROVIDER SUMMAY STATEMENT OF DEFICIENCIES (B) CATHERY WAS THE PROPERTY WAS THE PROCEDED BY FULL (B) CANDIDATE SUMMAY STATEMENT OF DEFICIENCIES (CA) MANUAL THAT OF THE APPROPRIATE (CA) MANUAL THAT OF CORRECTION (CE) MANUAL THAT OF CORRECTION (CE) CANDIDATE SUMMAY STATEMENT OF DEFICIENCIES (CE) CARDINARY SHAN OF CORRECTION (CE) CANDIDATE SUMMAY STATEMENT OF DEFICIENCIES (CE) CARDINARY SHAN OF CORRECTION (CE) CANDIDATE SUMMAY STATEMENT OF DEFICIENCIES (CE) CARDINARY SHAN OF CORRECTION (CE) CARDINARY	Division	n of Health Care Fac	lities						
STREET ADDRESS, CITY, STATE, 2P CODE 303 SOUTH ROYAL OAKS BLVD PREPIX CACH DEFICIENCY WIST SER PRECEDED BY FULL TAG D 829 Continued From page 3 blocodborne vivuses (HBV, hepatitis C virus and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters, fingerstick devices, insulin pens) are sharedUnsafe practices during assisted monitoring of blood glucose and insulin administration into that have contributed to transmission of HBV or have put persons at risk for infection include: Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses." During an interview on 6/26/12 at 9-45 AM, Licensed Practical Nurse (LPN) #1 stated there was 1 glucometer in the Memory Care Unit She stated currently there are 3 residents that get their glucoses checked with the glucometer each morning. When asked by the surveyor how offen the glucometer is cleaned, LPN #1 stated one time a day, after the glucometer had been used to check all 3 residents glucose. D 710 C) An ACLF shalt dispose of medications as follows: (a) Upon discharge or death of a resident, unused medications shalt be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider.	STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NU		A. BUILDI	NG	COMPL	ETED	
## BELVEDERE COMMONS OF FRANKLIN 1920	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY	STATE, ZIP CODE	0.0		
PRÉFIX TAG D 629 Continued From page 3 bloodborne vivuses (HBV, hepatitis C virus and HIV) through contaminated equipment and supplies if devices used for testing another insulin administration (e.g., blood glucose meters, fingerstick devices, Insulin pens) are shared. Unsafe practices during assisted monitoring of blood glucose and Insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include: Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses." During an interview on 6/26/12 at 9:45 AM, Llcensed Practical Nurse (LPN) #1 stated there was 1 glucometer in the Memory Care Unit. She stated currently there are 3 residents that get their glucose checked with the glucometer each morning. When asked by the surveyor how often fine glucometer is cleaned, LPN #1 stated one time a day, after the glucometer had been used to check all 3 residents glucose. D 710 1200-08-25-07 (6)(a) Services Provided (6) An ACLF shall dispose of medications as follows: (a) Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider.	l <u>.</u>			303 SQU					
bloodborne vivuses (HBV), hepatitis C virus and HIV) through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., plood glucose meters, fingerstick devices, insulin pens) are shared. Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include: Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses." During an interview on 6/26/12 at 9:45 AM, Licensed Practical Nurse (LPN) #1 stated there was 1 glucometer in the Memory Care Unit. She stated currently there are 3 residents that get their glucose checked with the glucometer each morning. When asked by the surveyor how often the glucometer is cleaned, LPN #1 stated one time a day, after the glucometer had been used to check all 3 residents glucose. D710 1200-08-25-07 (6)(a) Services Provided (6) An ACLF shall dispose of medications as follows: (a) Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
Based on observation, and interview, it was	D 710	bloodborne vivuses HIV) through contar supplies if devices used in the vivus administration (e.g., fingerstick devices,Unsafe practices of the vivus administration (e.g., fingerstick devices,Unsafe practices of the vivus and plucose and in the vivus and plucose and in the vivus and plucose meter without cleaning and uses." During an interview of Licensed Practical Nas 1 glucometer in stated currently there their glucose checke morning. When asket the glucometer is cleating a day, after the check all 3 residents 1200-08-2507 (6)(a) (6) An ACLF shall diffollows: (a) Upon discharge of unused medications resident, family mem unless specifically prophysician or other au	(HBV, hepatitis C viminated equipment a used for testing and/o blood glucose mete Insulin pens) are shaduring assisted monification administration transmission of HBV or infection include: I or more than one properties of disinfecting it in bethe on 6/26/12 at 9:45 Allurse (LPN) #1 stated the Memory Care United with the glucometer death of the surveyor help and J. LPN #1 stated glucometer had been glucose. In Services Provided aspose of medication or death of a resident shall be released to the provided by the attention of the provided healthcare provided by the attention of the provided by the provided by the attention of the provided by th	nd or insulin rs, ared. toring of that or have Using a terson ween W, d there nit. She is get ter each ow often it one n used to s as t, the intative ding orovider.		used on each resident. This pinas already begun. The pracicleaning the glucometer after resident will be monitored to Wellness Director. The Exported of the Community of the Community of the community of the cleanings are held every other Documentation of the cleaning be kept and reviewed in W. Director meetings, which are	ractice tice of reach by the cutive ellness meet- week ng will ellness	08/08/12	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI TNPL537157	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE S COMPL	
314415 OF -	200 200 00 01 01 00				ATATE ZID CODE	U0/2	0/2012
NAME OF E	PROVIDER OR SUPPLIER				STATE, ZIP GODE		
BELVED				TH ROYAL N, TN 3706	OAKS BLVD 4		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD 6E	(X5) COMPLETE DATE	
D 710	Continued From pa		_	D 710			
	determined the facility failed to dispose of discontinued medications in 2 (Pink and Blue Community) of 3 medication storage areas in the Memory Care Unit (MCU).						
	The findings included: 1. Observation on 6/26/12 at 8:30 AM in the Pink Community, revealed in the medication cart there was 1 Glucagon Kit with an expiration date of 2/21/12. During an interview, Licensed Practical Nurse (LPN) #1, present at the time of the above finding in the Pink Community stated the Glucagon Kit belonged to a resident who had been discharged from the facility about 3 months ago. LPN #1 verified the medication was not properly disposed of after the resident was discharged. 2. Observation on 6/26/12 at 8:40 AM in the Blue Community, revealed in the medication				5. Whenever a resident leaver facility, any unused medication be released to the resident's member or legal represel unless physician says not practice will be monitored to nurse supervisors and the We Director. This practice will immediately. This will als reviewed by the Executive Director meetings, are held every other week, mentation of discarding medically wellness Director meetings, are held every other week.	n will family ntative This by the elliness begin o be ctor in which Docutations ed in	08/08/12
	ofrigerator there was 1 bottle Humulog Insulin 5/25 and 1 Injection of Forteo. uring an interview, LPN #1, present at the time the findings in the Blue Community, stated the sident who had received the Humulog insulin a longer resided at the facility. She stated the sident who had received Forteo injections still sided at the facility, but the Forteo had been scontinued about 2 months ago. LPN #1 wrifted the medication had not been properly sposed of by the facility.		D 712	6. Whenever a resident leav facility, any unused medicative released to the resident's member or legal represe unless physician says no practice will be monitored I nurse supervisors and the W. Director. This practice will immediately. This will also reviewed by the Executive Director meetings, are held every other week, mentation of discarding medicately.	on will family ntative This by the ellness begin to be ector in which Docu- cations	08/08/12	
	(6) An ACLF shall di follows:		3 88		will be kept and review Wellness Director meetings, are held every other week.	ed in	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: TNPL537157				(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED 08/26/2012	
NAME OF F	ROVIDER OR SUPPLIER	1	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	ERE COMMONS OF F	-RANKLIN		TH ROYAL (N, TN 3706	DAKS BLVD 4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	-ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 712	(c) Any non-schedumisbranded, expired under proper conditional lilegible or missing library disposed of at the A	ge 5 Lited drug or device the discriminated, or not not not not not not abels shall be proper CLF in the presence certified professional	kept with y of	D 712			
	dispose of expired in The findings include 1. Review of the faci expired medications Lantus and Novolog 28 days from the time	lew, observation and ermined the facility fandications. d: iilly medication policy revealed Humulin, N insulins should be did they are opened. Tubersol must be disc	for (7) lovolin, scarded he		Novolog insulins will be of days from the time they Other medications cover policy such as Tubers discarded 30 days aff. This will begin immediate monitored by the nurse and Wellness Director as by the Executive Director	antus and discarded 28 are opened. ered by this of must be ere opening ately and be esupervisor and reviewed actor at the	08/08/12
	2. Observation on 6/ the medication refrig 2 opened containers contained document been opened. Also in Novolog insulin with and 1 opened vial Hid documentation it had	26/11 at 8:45 AM, re- lerator in the MCU the of Tubersol. Neither attion of the date they in the refrigerator was an expiration date of umulin R Insulin with	had 1 vial 3/12/12		Wellness Director mee are held every other was mentation of discarded will be kept on file and the Wellness Director met. 8. Expired medication disposed of according to will begin immediately monitored by the nurs	tings, which week. Documedications reviewed at cetings. Ins will be policy. This and will be supervisor	08/08/12
	During an interview, Director for the MCU the finding verified th confirmed it could no days on the Tuberso had not been dated v	I, both present at the le above findings. Bo of be determined whe I would be since the I	ness time of th n the 30		and Wellness Director aby the Executive Director meeting are held every other mentation of discarded will be kept on file and the Wellness Director mentation.	and reviewed ector at the etings, which week. Documedications	

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Division	Division of Health Care Facilities						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL537157		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/26/2012	
	TOOL MORE OR OLLOWING	1111 2507 101	OTREET AN	DRESS, CITY, STATE, ZIP CODE			
	ROVIDER OR SUPPLIER PERE COMMONS OF F	FRANKLIN	303 SOU		DAKS BLVD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ATO BE	(X6) COMPLETE DATE	
	the Assisted Living Novolog insulin date 5/15/12, 1 bottle Hubeen opened 5/19/1 dated it had been on vial Tubersol that dibeen opened. During an interview Wellness Director of the above finding to timely discard of confirmed it could mays on the Tubersol dated when opened 1200-08-2507 (7)(c)	i/26/12 at 9:30 AM, re Unit (AL) there was a ed it had been opene mulog insulin dated it 12, 1 bottle Novolog i pened 5/13/12 and 1 d not document when on 6/26/12 at 9:30 A f the AL, present at t s verified the facility lithe expired insulins. In the AL present at t or be determined who is would be since it would be since it wo c)5. Services Provide provide personal services and interview, it was the facility the tast of the deal the in and interview, it was the facility the facility the in and interview, it was the facility the facility the in the Memory Care stant Living (AL) unit,	t bottle id it had it had nesulin opened n it had M, the hetime had failed She en the 30 vas not ed vices as sanitary	D 732	9. Expired medications we disposed of according to policy will begin immediately and wonlitored by the nurse sup and Wellness Director and report the Executive Director Wellness Director meeting, mentation of discarded medically will be kept on file and reviet the Wellness Director meeting which are held every other were	r. This will be ervisor viewed at the Docu- cations wed at etings,	08/08/12

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PAGE 24/30 * RCVD AT 8/30/2012 6:33:38 PM [Central Daylight Time] * SVR:NAS-LCLFAX2/3 * DNIS:8093 * CSID:96158715728 * DURATION (mm-ss):05-57

Division	of Health Care Faci	ilities					
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL637157		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SI COMPLE 06/2	
		IMPLOSTIST			STATE 310 DODE	1 00/2	0.2012
NAME OF	PROVIDER OR SUPPLIER	1	l		STATE, ZIP CODE		
BELVEC				TH ROYAL (N, TN 3706	DAKS BLVD 4		
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D 732	Continued From pa	ge 7		D 732			
	6/26/12 at 8:30 AM communities. Each area that contained stove/microwave, a a. Observation of the Community on 6/26 following: In the refiplastic bag grated owhen it had been of a been placed in the molded sweet potation of a been placed in the molded sweet potation of documentation of a been placed i inside of the refrigermany liquid and foo The kitchen counter of cookies. In the martially eaten waffit lower kitchen cabine undated bags of potation of the Community on 6/26, the refrigerator therefrigerator therefrigerator and free and food spills.	nd cabinets. The kitchen in the Pink 1/12 at 8:40 AM, reverence and placed in can Ensure with no resident name or with refrigerator, ½ uncouncy, 1 large container in from was an uncover interested and placed in the refrigerator. Both and freezer con d spills. Top was an uncover icrowave on a plate was and piece of sausa ats were 9 large, ope tato chips and cookie e kitchen in the Blue 1/12 at 9:00 AM, rever e was 1 large contain e container pimento and and were not da ded, Both the inside o izer contained many cabinets in the kitche abinets in the kitche	aled the large nentation the large nervers 5		10. Assignments of staff to kitchens clean and sanitary been made. This has documented. Also, all food liquids will be labeled with the they are opened. Documente these assignments will be moby the nurse supervisors, W. Director and reviewed by Executive Director. All of the begin immediately. This will reviewed by the Executive Director meetings, are held every other week.	have been is and he date estimated fellness by the his will also be ector in	08/08/12

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DIVISION	or Health Care Pac	ilities				(X3) DATE SL	IDVEY
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE	RVCLIA	(X2) MULT	IPLE CONSTRUCTION	COMPLE	TED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILOIN	G		
		TNPL537157		B. WING _	·	06/26	3/2012
NAME OF F	NOT TOTAL OF BUILDING	INFLOST 107	STREET ADI	DRESS, CITY.	STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		l		OAKS BLVD		
BELVED	ERE COMMONS OF I	FRANKLIN		N, TN 37064	f		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BĒ I	(X5) COMPLETE DATE
D 732	not dated when the the cabinet doors he cabinet and 1 cabinet. c. Observation in the 6/26/12 at 9:15 AM container cottage or plmento cheese with either had been operfrigerator and from the container cottage. Observation in the revealed there were and cookles not datopened. 2. Observation of the 6/26/12 at 9:40 AM refrigerator there were and cookles or there were and cookles or the datopened. 3. During interviews MCU, present during the above findings in the cabinet and the cabinet are the cabinet and	y had been opened. ad missing knobs to het did not have a doing yellow Community, revealed there was the no documentation ened. Both the inside exer contained many lower kitchen cabinet a 3 large bags of pote ted when they had be the kitchen in AL Unit revealed in the walk as 1 gallon container to dated when they had be the kitchen in the walk as 1 gallon container to dated when they had be the tour of the MC on the MCU. The Wellness Direct gat the tour of the MC on the MCU. The Wellness do do not start the MCU. The Wellness do do not start the MCU. The Wellness do do not start the MCU. The Wellness do not start the MCU.	open the or. on 1 ontainer when of the liquid liqu	D 732	11. Assignments of staff to kitchens clean and sanitary been made. This has documented. Also, all food liquids will be labeled with the are opened. Documente these assignments will be moby the nurse supervisors, W Director and reviewed be Executive Director. All of the begin immediately. This will reviewed by the Executive Dir Wellness Director meetings, are held every other week. 12. The dietary staff will matter all foods and liquids are	have been s and e date ation of initored ellness y the nis will also be ector in which	08/08/12
	employee refrigerate The Dietary Manage the Al. kitchen, veri	present during the to or verified the above er, present during the fied the above finding liquids should be lai bened.	findings. e tour of gs. She		with the date they are opene Assisted Living unit in the refrigerator. This will be monit	d in the walk-in ored by ssistant Director. ons by	
D 832	1200-08-2508 (9)(and Transfers			D 832	filose monitoring ten so rope	,	
	survey staff with two	ng secured units shai elve (12) months of t ace information speci	he j			:	

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Divisio	on of Health Care Fac	ilities		FORM APPROVED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE TNPL537157	p. G	IULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER		REET ADDRESS, C	TY STATE A TON SOLING -
	303 801			AL OAKS
BELVE	DERE COMMONS OF I	RANKLIN FI	RANKLIN, TN 3	7064 to a stront cours
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D 832	Continued From pa	ge 9	D 832	to be done! the
		residents at its annual	İ	Educate joy Mark on tickler
	survey:		J	Mark on tickler
	each resident 's int performed a quarte	o-to-date documentation erdisciplinary team has rly review as to the placement in the secure		there is better ect wisk corective author wisk
	was determined the documentation of extern quarterly review appropriateness in (Resident #4, #5) of (MCU) residents. The findings including the was admitted to Diagnoses included documentation that interdisciplinary tear Medical record reviews was admitted to diagnoses included was documentation 10/17/11 and 2/10/1	ecord review and intervi- facility failed to have ach resident's interdiscip set to show the resident's the secured unit for 2 2 sampled Memory Car ed: where the MCU on 1/6/12. Dementia. There was n any quarterly reviews by n had been completed. where for Resident #5 reves the MCU on 3/17/11. If Alzheimer's disease. Th of a quarterly review on 2. at the time of the finding antified the facility had fair	ilinary is Unit 13 aled of the 14 aled er ere	13. Ongoing and up-to-date documentation that each resident's interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit will be done on each resident. This is the responsibility of the Wellness Director and will be monitored by the Executive Director and Assistant Director. Documentation will be reviewed by the Executive Director and Assistant Director in the Wellness Director meeting every other week. 14. Ongoing and up-to-date documentation that each resident's interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit will be done on each resident. This is the responsibility of the Wellness Director and will be monitored by the Executive Director and Assistant Director. Documentation will be reviewed by the
D1036	1200- 08-2510 (8)(t		D1036	Executive Director and Assistant Director in the Wellness Director meeting every other week.
	(8) An ACLF shall e	nsure that:		
Division of He	ealth Care Facilities			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
TNPL537157			06/26/2012					
BELLYEDEDE COMMONS OF FRANKLING			DDRESS, CITY, STATE, ZIP CODE JTH ROYAL OAKS BLVD IN, TN 37064					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	SHOULD BE COMPLETE		
D1036	(b) The ACLF stores janitorial supplies away from the kitchen, food storage area, dining area or other resident accessible areas;			D1036				
						•		
	This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store janitorial supplies away from the kitchen/ food storage area in 3 (Kitchens in Pink, Blue, Yellow Units in Memory Care) of 4 kitchen areas toured.							
	Unit (MCU) revealed cleaning supplies ar stored in the lower of Pink, Blue and Yello		of nts were ns of the		15. Janitorial supplies will be	stored	08/08/12	
	During an interview, the MCU Wellness Director stated that is where the cleaning supplies have always been kept. 1200-08-2510 (8)(d) Life Safety (8) An ACLF shall ensure that: (d) The ACLF cleans floor and dryer vents as frequently as needed to prevent accumulation of lint, soll and dirt.			1038	away from the kitchen, food area, dining area and other raccess areas. The supplies moved immediately and this v	storage esident will be		
D1038					be allowed again. This monitored by the Wellness D	will be Director		
					Assistant Director and Ex Director. This will be reviewe Wellness Director meeting every other week by the Ex Director.	at the		
	This Rule is not me Based on observation determined the facility vents in 2 (Pink and laundry rooms were	on and interview, it wa ty failed to ensure th Blue Community) of	e dryer					
İ	The findings included		aglad tha			2		
.] '	Observation on 6/26	mz at nutuu AM, rev	egigo IUS					

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Division of Health Care Facilities								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL637157		(X2) MULTIPLE CONSTRUCTION . A. BUILDING		(X3) DATE SURVEY COMPLETED 06/26/2012		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	SHOULD BE COMPLE		
D1038	Continued From page 11			D1038				
	dryer vents in the laundry rooms in the Pink and Blue Community of the Memory Care Unit (MCU) revealed the vents had a heavy build up of lint. During an interview, at the time of the findings, the MCU Wellness Director verified the heavy lint build up in the dryer vents.				16. Dryer vents with the hea	vy lint	08/08/12	
					build-up will be cleaned a removed immediately. This done and reviewed by the fi	vill be ainten-		
D1040	1200-08-2510 (10)(a) Life Safety		D1040	ance Director. This will be monitored by the Wellness Director, Assistant				
	(10)An ACLF shall r environment in a sa by doing at least the	e, clean and sanitar	y manner		Director and Executive D This will be discussed and ret at the Wellness Director in held every other week b	irector. viewed neeting y the		
	(a) Prohibit any con conductive to the har rodents or other veri	boring or breeding o			Wellness Director, Assistant E and Executive Director.	Pirector		
	This Rule is not me Based on observation determined the facility physical environment manner in the Memo	n and interview, it w ty failed to maintain t t in a clean and sani	the tary					
	The findings included 1. Observation in the revealed in the residuol 101,108 and 112 the shower. The commo black and red ring at the commode was word the commode. 2. Observation in the 6/26/12, revealed in the commode 208 and 209 to showers. Each comming at the top of the	Pink Community on ent bathrooms in roo re was mold in the ro de in each above roo the top of the water ery dirty around the in Blue Community on the resident bathroon here was mold in the node had a black an	oms esident's om had a line, and nside top ms in ed d red		17. Every resident's bathroom Memory Care unit will imme be examined to insure safe and sanitary conditions exis will be the responsibility Executive Director, Wellness I and Assistant Director. This continual process going for Daily rounds will be mad documentation kept of the rounds the Executive Director, Ac Director and Wellness Director.	ediately , clean t. This of the Director vill be a orward. le and unds by ssistant	08/08/12	

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Division of Health Care Facilities								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. EUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/26/2012		
l		THELOSTION	OTDEET AD	DDECE CITY	STATE ZID CODE	0012	UIZU IZ	
DELVEDENE COMMONS OF FRANKLING			DDRESS, CITY, STATE, ZIP CODE TH ROYAL OAKS BLVD N, TN 37064					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REPERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETE		
D1040	Continued From page 12 both commodes were very dirty around the inside top of the commodes. 3. Observation in the Yellow Community on 6/26/12 revealed room 305 and 308 had mold in the showers. Each commode had a black and red ring at the top of the water line and. Both commodes were very dirty around the inside top of the commodes. During an interview at the time of the findings, the MCU Wellness verified the facility had failed to maintain a clean and sanitary environment.			D1040	17. Every resident's bathroom in the Memory Care unit will immediately be examined to insure safe, clean and sanitary conditions exist. This will be the responsibility of the Executive Director, Wellness Director and Assistant Director. This will be a continual process going forward. Daily rounds will be made and documentation kept of the rounds by the Executive Director, Assistant Director and Wellness Director.		08/08/12	
	the resident's pers minimum the followi	i. An ACLF shall ensonal record includes ing: ecurity Number, vete marital status, age, sovider and number, and dicaid number, and	sure that at a eran sex, any		Director and veniness shows			
	This Rule is not me Based on medical rewas determined the medical record inclunumber and marital #3, #4 #5) of 5 samp. The findings include Medical record revie #5 revealed there was	ecord review and inte facility failed to ensu ded veteran status a status for 4 (Resider oled residents. d: w for Resident #2, #3	re the nd nt # 2,		18. Documentation of obtain Veteran status and marital state begin immediately. Obtaining information will be the responsible to the Community Outreach Ewellness Director, Assistant and Executive Director. This mentation will be reviewed Wellness Director meeting every other week.	atus will ng this nsibility Director, odirector docu- at the	08/08/12	

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